AMENDMENTS TO THE CLAIMS

The listing of claims will replace all prior versions, and listings, of claims in the application.

Listing of Claims:

1. (Previously Presented) A method in a computer system for predicting a level of consumption of healthcare resources by modeling utilization of healthcare resources in a target period based on a plurality of provider claims from a base period maintained for a member of a healthcare plan, the method comprising:

calculating a burden of illness score for the member based on the plurality of provider claims, wherein the burden of illness score is a number; and

computing a utilization score for the member based on the burden of illness score and at least one explanatory variable, wherein a plurality of utilization scores is computed that correspond to each of a plurality of members in a health plan.

2. (Original) The method of claim 1 wherein the provider claims include medical claims and pharmacy claims.

3. (Original) The method of claim 1 wherein the plurality of provider claims include only pharmacy claims.

4. (Original) The method of claim 1 wherein the provider claims include only medical claims.

5. (Previously Presented) The method of claim 1 further including, prior to the calculating step, extracting a data set from the plurality of provider claims, the data set including only information from the base period relevant to healthcare utilization during the target period, and further wherein the calculating step is based on the data set.

6. (Previously Presented) The method of claim 5 further including, after the extracting step, the step of cleaning the data set to remove obviously erroneous information by comparing categories of the data set to acceptable values.

7. (Original) The method of claim 5 further including, after the extracting step, the step of placing a plurality of pharmacy codes, representing a prescribed medication, into a plurality of therapeutic pharmacy classes.

8. (Original) The method of claim 7 wherein the plurality of therapeutic pharmacy classes are GC3 classes.

9. (Previously Presented) The method of claim 7 wherein the burden of illness score is derived by summing a plurality of weights corresponding to each of the plurality of therapeutic pharmacy classes present for the member.

10. (Previously Presented) The method of claim 7 wherein the burden of illness score is derived by summing a plurality of weights corresponding to each of the plurality of therapeutic pharmacy classes present for the member and a plurality of weights corresponding to relevant combinations of therapeutic pharmacy classes present for the member.

11. (Original) The method of claim 5 further including, after the extracting step, the step of placing a plurality of disease codes from the medical claims, representing diseases treated, into a plurality of disease classes.

12. (Original) The method of claim 11 wherein the disease classes are CCG classes.

13. (Original) The method of claim 11 wherein the disease classes are CCG categories.

14. (Previously Presented) The method of claim 11 wherein the burden of illness score is derived by summing a plurality of weights corresponding to each of the plurality of disease classes present for the member.

15. (Previously Presented) The method of claim 14 wherein the plurality of weights is an average incremental cost associated with each of the plurality of disease classes associated with a group for a benchmark population.

16. (Original) The method of claim 1 further including, prior to the calculating step, the steps of determining the presence of a plurality of medical episodes and placing the plurality of claims data into a plurality of groups based on a medical episode.

17. (Original) The method of claim 16 wherein the plurality of groups are Clinical Care Groups.

18. (Original) The method of claim 16 wherein the pharmacy claims in the plurality of claims data are assigned to one of the plurality of groups based on a relationship to corresponding medical claims indicating the presence of the medical episode.

19. (Original) The method of claim 16 wherein the plurality of claims are only medical claims.

20. (Original) The method of claim 16 wherein the calculating step includes multiplying each of the plurality of groups representing a medical episode, present for the member, by a predetermined weight factor and summing the products to achieve a single number.

21. (Original) The method of claim 20 wherein the predetermined weight factor corresponding to one of the groups, representing a medical episode, is adjusted based on the presence of a comorbidity for the group, in the data in the plurality of provider claims.

22. (Original) The method of claim 20 wherein the predetermined weight factor corresponding to one of the groups, representing a medical episode, is adjusted based on the presence of a complication for the group in the medical claims.

23. (Original) The method of claim 20 wherein the predetermined weight factor corresponding to one of the groups, representing a medical episode, is adjusted based on the age of the member.

24. (Original) The method of claim 20 wherein the predetermined weight factor corresponding to one of the groups, representing a medical episode, is adjusted based on the gender of the member.

25. (Previously Presented) The method of claim 20 wherein the predetermined weight factor corresponding to one of the groups, representing a medical episode, is based on an average incremental cost associated with a group for a benchmark population.

26. (Original) The method of claim 20 wherein the predetermined weight factor corresponding to one of the groups, representing a medical episode, is based on an average incremental cost for a group during the base period.

27. (Original) The method of claim 1 wherein the at least one explanatory variable is a number indicating in which of a plurality of age categories the member belongs.

28. (Original) The method of claim 1 wherein the at least one explanatory variable is a number indicating the gender of the member.

29. (Original) The method of claim 1 wherein the explanatory variable is a factor that indicates a number of chronic claims for the member.

30. (Original) The method of claim 1 wherein the explanatory variable is a factor that indicates a number of chronic drug categories, based on the plurality of claims data, for the member.

31. (Original) The method of claim 1 wherein the explanatory variable is a factor that indicates the recency of claims for the member.

32. (Original) The method of claim 1 wherein the explanatory variable is the sum of chronic medical costs from the pharmacy claims and the medical claims.

33. (Previously Presented) The method of claim 1 further including, after the computing step, the step of calculating a relative risk for the member of a group by dividing the utilization score by an average utilization score for the group.

34. (Previously Presented) The method of claim 1 further including, after the computing step, the step of calculating a relative risk for the member of a group by dividing the utilization score by an average utilization score for a benchmark group.

36. (Previously Presented) The method of claim 1 wherein the plurality of utilization scores is computed based on only the information from the pharmacy claims.

37. (Previously Presented) The method of claim 36 further comprising the step of identifying a high risk set of members by selecting the members having utilization scores that exceed a predetermined level.

38. (Previously Presented) The method of claim 37 further comprising the step of computing a second plurality of utilization scores for the high risk set of members based on the information in both the pharmacy claims and the medical claims.

39. (Previously Presented) The method of claim 1 further comprising, prior to the computing step, calibrating the model by comparing a computed utilization score against healthcare resource utilization for a known target period.

40. (Original) The method of claim 39 wherein the healthcare resource utilization is derived from both medical claims and pharmacy claims.

41. (Original) The method of claim 39 wherein the healthcare resource utilization is derived from only medical claims.

42. (Original) The method of claim 39 wherein the healthcare resource utilization is derived from only pharmacy claims.

43. (Previously Presented) The method of claim 1 further comprising, prior to the computing step, calibrating the model by comparing a computed utilization score against healthcare resource utilization for a known target period, for only utilization due to chronic medical conditions.

44. (Original) The method of claim 43 wherein the healthcare resource utilization is derived from both medical claims and pharmacy claims.

45. (Original) The method of claim 43 wherein the healthcare resource utilization is derived from only medical claims.

46. (Original) The method of claim 43 wherein the healthcare resource utilization is derived from only pharmacy claims.

47. (Previously Presented) The method of claim 1 further comprising, prior to the computing step, the step of calibrating the model by comparing the calculated burden of illness score against healthcare resource utilization for a known target period.

48. (Previously Presented) A method in a computer system for predicting use of healthcare resources by a plurality of plan members in a healthcare plan, comprising:

for each of the plurality of plan members in the healthcare plan:

collecting prior healthcare use claims data for the plan member;

computing a utilization score using, at least in part, a multiple linear regression equation, wherein the act of computing comprises computing a burden of illness score; and

using the utilization score to predict healthcare resource consumption by the plan member.

49. (Previously Presented) A method in a computer system for determining consumption of healthcare resources by a plurality of plan members in a healthcare plan during a base time period, comprising:

for each of the plurality of plan members in the healthcare plan:

collecting prior healthcare use claims data for a plan member;

calculating a burden of illness score for the member based on prior healthcare use claims; and

computing a utilization score for the member based on the burden of illness score and at least one explanatory variable; and

using the computed utilization scores to identify plan members to whom preventive measures are recommended in an effort to reduce consumption of healthcare resources.